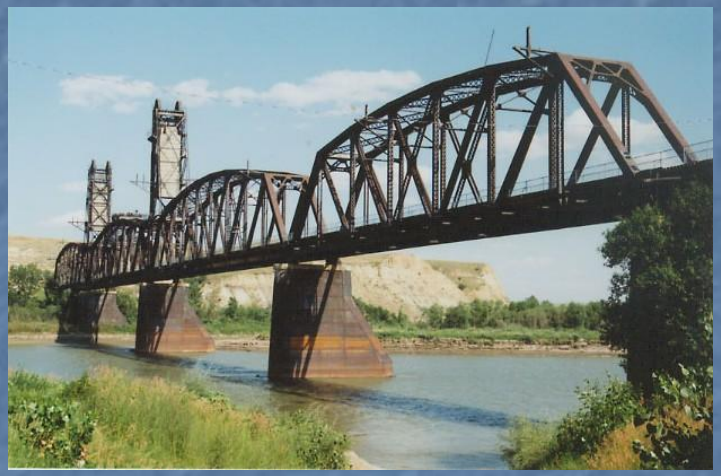
"An Unlikely Recipe for Success: hospital and local public health partnership supports diabetes self-management"



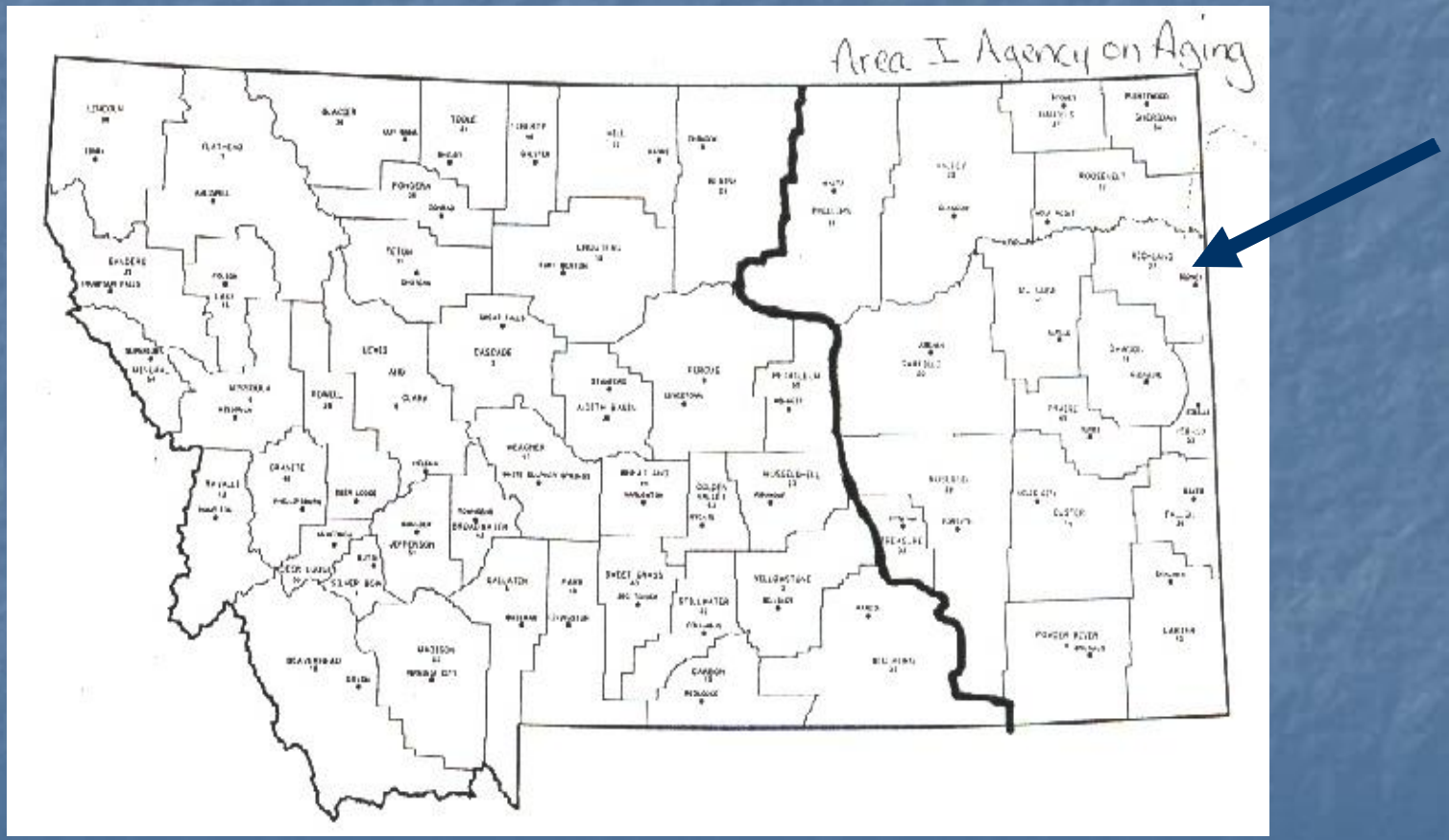
The Richland County Community Diabetes Project

Richland County, Montana

Lisa Aisenbrey, RD, Diabetes Project Director

This product was developed by the Richland County Community Diabetes Project at the Richland County Health Department in Sidney, MT. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Richland County, Montana



Community Profile

- Frontier, aging community on the border between North Dakota & Montana
- Sidney, Fairview, Savage, Lambert, Crane
- Population: 9,155 (4.6 persons per sq. mile)
- Farming (beets), ranching, oil, small business
- 1/3 older adults
- Median household income (1999) is 32K

Climate & location challenges

- Cold winters, hot & humid summers
- 250+ miles to nearest major hospital & specialists

Culture

- Scandinavian, German homesteaders, ranchers
- Seasonal migrant farmworkers (Hispanic, Native American)
- Near 2 Native American Reservations, one Indian Service area
- Small percentage Native American, Hispanic, Black American, Asian.
- Hardy, independent, stoic, resistant to change, wary of outsiders, private, loyal to neighbors and friends.

Nutrition in Eastern Montana

Physical Activity in Eastern Montana

Richland Health Network

- Richland County Commission On Aging
- Richland County Health Department
- Sidney Health Center (hospital, clinic, pharmacy, extended care, fitness center, assisted living)

DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

Washington University in St. Louis
SCHOOL OF MEDICINE

THE ROBERT WOOD JOHNSON FOUNDATION®

RTI INTERNATIONAL

Promoting ***self management*** of diabetes through primary care settings

Community collaborations to support ***self management*** of diabetes and diabetes care

Richland County Community Diabetes Project

- Adults with Type 2 Diabetes
- 15 member Advisory Board

- **Staff:**
  - Judy Lapan, Health Department Administrator
  - Lisa Aisenbrey, RD Diabetes Project Director (Health Dept. & Sidney Health Center)
  - Idelle Badt, Diabetes Project Coordinator
  - Susan Dahl, SHC Nurse for Education Center
  - Rebecca Miller, Administrative Assistant

Consultants:

Mary Madison, CDE

Phillip Weaver, MD, Medical Consultant

Community Collaboration

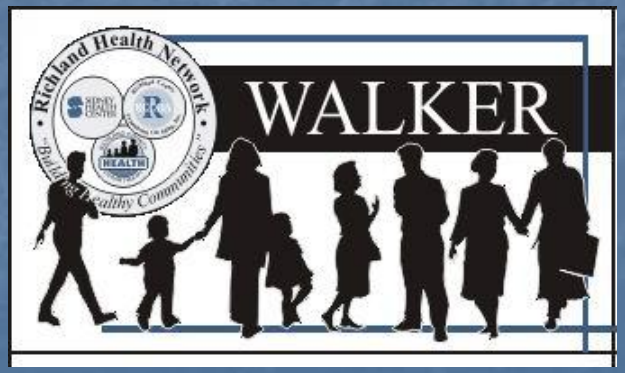
- Communities in Action
- WIC, At-Risk home visiting
- Richland County Nutrition Coalition
- Sidney Health Center Community Health Improvement Committee
- Parish Nursing
- RSVP
- Literacy Volunteers of America
- LIONS Club
- American Diabetes Association – Montana
- Montana Migrant Council (on Advisory Board)
- McCone County Senior Center
- Montana Diabetes Project
- Sidney Public Library
- Eastern Montana Mental Health
- Health Fair Planning Committee at hospital
- Media
- And more…

Project Components

- **Addressing the whole person with diabetes**
  - **Physical activity**
  - **Healthy eating**
  - **Social support**
  - **Diabetes education**

Physical Activity

- Strike Diabetes Out
- Walk NW North Dakota
  - Motivating short-term pushes, group & individual
- Indoor walking opps increased (community)
  - 8 free, 1 pay
  - Varied hours, day and night
  - Free pedometer
- Walking Rx



Name:_____

Date:_____

Exercise Prescription

Walk (or _____)

_____ times per week

for _____ minutes.

Additional Instructions:

_____

_____

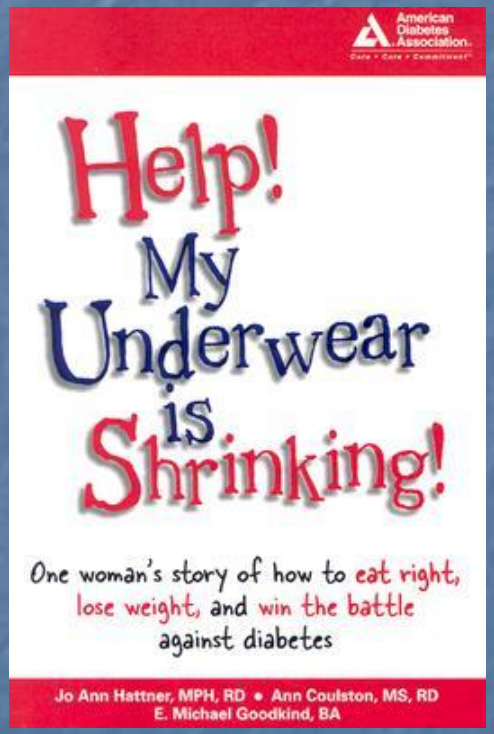
_____

Signature:_____

Healthy Eating

- Weight monitoring (Diabetes Watchers)
- Thin 2 Win
- Tasty Fork
- Nurtibase Software
- Recipe in newsletter
- Newspaper articles
- Health Fair booths
- Grocery Store Tours

Social support & Continuing Education



- Diabetes Education Group
- Goal Setting
- Newsletter
- Resources at Public Library
- Community Resource Book
- Stanford's Chronic Disease Self-Management Class
- Ambassadors (lay health workers)

Diabetes Education Center

- Formal group and individual diabetes self management education in medical setting
  - Housed at Sidney Health Center
  - Staff: RD, RN, Coordinator
- Physician referral required
- Coordinated by Public Health
  - Linked with community projects
  - Strong source of referrals
- Diabetes Quality Care Monitoring System
- Achieved ADA recognition!!

What ADA Recognition Means…

- Standardized, quality education for people with diabetes
  - National Standards for Diabetes Patient Education Programs
  - First recognized program: 1987
- Medicare requires ADA recognition for program reimbursement
- Enhances marketing via ADA logo use and website publicity
- Sustainability!

SHC Diabetes Education Program Recognized

Sidney Health Center's diabetes education program recently received recognition from the American Diabetes Association. This certified program ensures that Sidney Health Center offers high-quality education that is an essential component of effective diabetes treatment. Pictured (L to R) are Lisa Aisenbrey, RD; Susan Dahl, RN; and Rick Haraldson, CEO, with the certificate of recognition from the American Diabetes Association.

Sidney Health Center Diabetes Education Program Receives American Diabetes Assn. Award

The Sidney Health Center diabetes self-management education program was recently awarded Recognition from the American Diabetes Association (ADA). This program offers high-quality education services to the pa-

agement for participants.

Self-management education is an essential component of diabetes treatment. One consequence of compliance with the National Standards is the greater consistency in the quality and quan-

treating acute complications; preventing, detecting, and treating chronic complications through risk reduction; goal setting and problem solving; psychological adjustment; and preconception care, management during

Other Activities

- Health literacy training
- Motivational interviewing training
- Provider education
- Local Worksite Wellness Programs

Lessons learned

- Diabetes "label" not good for active program involvement.
- Working from community in, focusing on whole environment versus "strike diabetes out"
- Medical model – helps to get people interested
- Community model – available when they want it, adapt to their changing needs. "Drive thru" support.

- Involvement Perception Disconnection
- Some things people prefer to pay for – free does not always mean they will show up (Watchers vs Thin-2-Win)
- Culture – people want support – but on their terms, different for every person
  - – people prefer to do things on their own (steps). Just need a push.
- 77% of active participants surveyed (n=38) prefer to manage their diabetes on their own rather than with a friend or in a group

Results

- 101 Type 2 participants in database
  - 6 Type 1, included in activities
  - 6 from McCone County
- 54 Active or consider themselves "Active"
- Average A1c is 7.17 (n=45)
  - Although preliminary, of those who have both pre-program and current A1c's available, avg. decrease of 0.62 points has been noted
  - Highest = 12.4, Lowest = 5.2
  - Sidney Health Center standard = 6

Results, cont…

- 74% of surveyed participants report increase in physical activity (n=38)
- 50% of surveyed participants report weight loss (n=38)
- Watcher's Weight loss
  - 22 total in group, some maintaining, some losing (180 pounds lost)

The REAL Results

"RCCDP has kept me aware that diabetes is an every day thing that needs daily attention."

"RCCDP has started me walking and helped me keep doing it"

"It's fun and helpful to share with others."